U.S. Department of Labor

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Issue date: 11Jun2002

In the Matter of:	:	
	:	
ROBERT BELL, JR.,	:	
Claimant,	:	Case Number: 2001-BLA-53
	:	
v.	:	
	:	
CONSOLIDATION COAL COMPANY,	:	
Respondent,	:	
and	:	
	:	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,	:	
Party-in-Interest.	:	
. . . . .	:	

Joseph E. Wolfe, Esquire
For the Claimant

Douglas A. Smoot, Esquire
For the Respondent

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER - REJECTION OF CLAIM

Statement of the Case

This proceeding involves a request for modification of the denial of a miner's subsequent claim for benefits under the Black Lung Benefits Act as amended, 30 U.S.C. §§ 901 et seq. ("the

Act"), and the regulations promulgated thereunder.[1, 2] Since this claim was filed after March 31, 1980, Part 718 applies. §718.2 Because the Claimant Miner was last employed in the coal industry in Virginia, the law of the United States Court of Appeals for the Fourth Circuit controls (D-1, 2, 3). *See Shupe v. Director, OWCP,* 12 BLR 1-200, 1-202 (1989)(*en banc*).

Procedural History

The Claimant, Robert Bell, Jr., filed his initial claim for benefits under the Act on April 19, 1996 (D-1). The Department of Labor made an initial finding of entitlement on September 20, 1996, which the District Director affirmed on December 18, 1996 (D-32, 38). By letter dated January 10, 1997, Employer, Consolidation Coal Company, requested that the claim be forwarded to the Office of Administrative Law Judges for a formal hearing (D-42). Administrative Law Judge Stuart A. Levin presided at a hearing in Abingdon, Virginia on July 8, 1997 (D-59). Thereafter, on November 10, 1997, Judge Levin issued a Decision and Order--Denying Benefits based on his finding that, while the Claimant established that he has pneumoconiosis which arose out of his former coal mine employment, he did not establish that he is totally disabled by a respiratory or pulmonary impairment (D-60).Claimant appealed, and, in a Decision and Order dated November 19, 1998, the Benefits Review Board affirmed the denial of the claim (D-61, 65).

By letter dated December 19, 1998, Claimant notified the Benefits Review Board that he had filed a request for modification (D-66). On November 3, 1998, the District Director proposed that the denial of benefits should be modified to an entitlement of benefits based on Claimant's submission of CT scan evidence indicating the presence of complicated pneumoconiosis and invocation of the irrebuttable presumption of total disability set forth at §718.304 (D-76). However, on June 23, 2000 upon consideration of additional evidence indicating that there had been no mistake in a determination of fact or a change in condition, the District Director issued a Proposed Decision and Order Denying Request for Modification (D-86). Claimant timely requested a formal hearing (D-88).

Administrative Law Judge Mollie W. Neal convened a formal hearing in Abingdon, Virginia on March 22, 2001. The Claimant subpoenaed Roderick Pritchard, a pulmonary function technician who had administered pulmonary function testing to the Claimant in 1996 in conjunction with his

[1]All applicable regulations which are cited are included in Title 20, Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. Claimant's Exhibits are denoted "C-"; Director's Exhibits, "D-"; Employer's Exhibits, "E-"; and citations to the hearing transcript are denoted "Tr."

[2]Pursuant to the order of this tribunal dated February 15, 2001, which was issued pursuant to the Preliminary Injunction Order dated February 9, 2001, in *Nat'l Mining Ass'n v. Chao,* No. 00-CV03086 (D.D.C., Feb. 9, 2001), all parties briefed the issues of whether the amendments of the regulatory provisions at §§718.104(d), 718.201(a)(2), 718.201(c), 718.204(a), 718.205(c)(5), and 718.205(d) would affect the outcome of this claim. Since the injunction was lifted as of August 9, 2001, the issues subject to the briefing order are moot, and the amendments to Part 718, published in Fed. Regis. Vol. 65, No. 245, Wednesday, Dec. 20, 2000, which became effective on January 19, 2001, are applicable in accordance with their terms in this case, which was pending on the effective date of the amended regulations.

examination by Dr. Castle. Pritchard moved to quash that subpoena. Judge Neal granted that motion and issued an order, dated April 3, 2001, continuing the hearing.

A formal hearing was held before this tribunal on September 18, 2001, in Abingdon Virginia. In addition to the Claimant's testimony, ninety-four Director's Exhibits, three Claimant's Exhibits, and twenty-one Employer's Exhibits were admitted into the record. At the hearing, the parties agreed to jointly submit the deposition transcript of Pritchard. This tribunal advised Claimant to submit the deposition post-hearing as Claimant's Exhibit 4, which was admitted into evidence subject to later receipt. (Tr. 9, 16). Claimant did not submit the transcript, and it is, therefore, not part of the evidentiary record.[3]

Issues

1. Whether the Claimant has proved the existence of a mistake in a determination of fact, or a change of conditions since November 10, 1997?
2. Whether the Claimant has established that he has complicated pneumoconiosis, and, therefore, is entitled to the irrebuttable presumption of total disability due to pneumoconiosis at §718.304?
3. Whether the Claimant has proved that he is totally disabled by a respiratory or pulmonary impairment?
4. Whether such disability, if proved, is due to coal workers' pneumoconiosis?

[3] At the first hearing in this request for modification, Claimant objected for the first time to the inclusion in the record of Director's Exhibit 39, which was admitted to the record by Judge Levin in the initial claim, because it included a pulmonary function study administered by Roderick Pritchard, a pulmonary function technologist. At the time, it was unclear as to whether Mr. Pritchard was properly licensed to perform such testing in the state of Virginia due to the limited nature of his job duties, his practice as a pulmonary function technologist for over thirty years, and relatively recent changes in Virginia law. While Claimant alleged during that first hearing that Mr. Pritchard was not appropriately qualified and licensed to administer the pulmonary function test in question, after causing a continuance and eliciting the deposition of Mr. Pritchard, Claimant has put forth no affirmative evidence or argument in support of his allegation. Pursuant to §718.103(c), in the absence of evidence to the contrary, compliance with the requirements of Appendix B--Standards for Administration and Interpretation of Pulmonary Function Tests shall be presumed. Accordingly, because the record contains no evidence to the contrary, this tribunal finds that the pulmonary function study administered by Mr. Pritchard to the Claimant on November 19, 1996, was administered in compliance with the regulations. Moreover, this tribunal notes that the pulmonary function study was invalidated by Dr. Castle and Mr. Pritchard due to the Claimant's poor cooperation and failure to meet the reproducibility standard described in Appendix B to Part 718 (2)(ii)(G). Judge Levin noted and properly considered the invalidity of the pulmonary function study in his consideration of the evidence in the Claimant's initial claim, and, therefore, no mistake in a determination of fact was made in the admission of Director's Exhibit 39.

Findings of Fact, Conclusions of Law, and Discussion

Benefits under the Act are awardable to persons who are totally disabled due to pneumoconiosis within the meaning of the Act. For the purpose of the Act, pneumoconiosis, commonly known as black lung, means a chronic dust disease of the lung, and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. A disease arising out of coal mine employment includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. §718.201. In order to obtain federal black lung benefits, a claimant-miner must prove by a preponderance of the evidence that: "(1) he has pneumoconiosis; (2) the pneumoconiosis arose out of his coal mine employment; (3) he has a totally disabling respiratory or pulmonary condition; and (4) pneumoconiosis is a contributing cause to his total respiratory disability." *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 529, 21 BLR 2-323 (4th Cir. 1998); *see Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1195, 19 BLR 2-304 (4th Cir. 1995); 20 CFR §§718.201-.204 (1999); *Gee v. W.G. Moore & Sons*, 9 BLR 1-4 (1986). Additionally, § 718.304 provides an irrebuttable presumption of total disability due to pneumoconiosis if the miner is suffering from a chronic dust disease of the lungs of an advanced degree frequently referred to as complicated pneumoconiosis. *See Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1,7,11 (1996); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 255 (4th Cir. 2000).

Background and Coal Mine Employment

The Claimant was born on September 5, 1940, completed twelve years of formal education, and is a lifelong non-smoker (D-1; Tr. 22). The Miner has one dependent for purposes of augmentation of benefits under the Act: his daughter, Ashley Sue, who was born on September 18, 1983 and is currently attending college (D-1,11, 12; Tr. 23). Claimant alleges that he completed seventeen years of coal mine employment, and the Employer does not dispute Judge Levin's finding of eleven and three-quarters years based on Social Security Records, Employer's records of the Claimant's employment, and the Claimant's employment history form (D-60, Tr. 8). Based on review of the evidentiary record, this tribunal finds that the Miner's Social Security records and the Employer's employment record for the Miner indicate that Judge Levin correctly determined that the Claimant completed eleven and three-quarters years of coal mine employment between April 28, 1975 and February 15, 1992 (D-4, 6).

Throughout his coal mine employment, Claimant worked at the mine surface as a rock driller and shooter (D-3; Tr. 18). Claimant was exposed to both rock dust and coal dust (Tr. 26). After he was laid off by Employer in 1992, Claimant worked for W & L Construction as a certified blaster on highway construction, specializing in the laying out of the holes to be blasted, the spacing and burden, and the drills to be used (D-59 at 18-19). Claimant worked for W & L Construction from January 1993 through October 1994 (D-6, 59 at 19).

Modification: Change in Conditions or Mistake in a Determination of Fact

Claimant's request for modification is governed by§725.310, which provides that any party may request modification of an award or denial of benefits if such request is filed within one year of the denial alleging a change in conditions or mistake in a determination of fact. Where mistake of fact forms the grounds for the modification request, new evidence is not a prerequisite, and a mistake of fact may be corrected whether demonstrated by new evidence, cumulative evidence, or further reflection on evidence initially submitted. *Kovac v. BCNR Mining Corporation,* 16 BLR 1071 (1992), *modifying* 14 BLR 1-156 (1990). If no specific mistake is alleged, but the ultimate determination of entitlement is challenged, the entire record must be examined for a mistake in a determination of fact. *See Jessee v. Director, OWCP*, 5 F.3d 723, 18 BLR 2-26 (4th Cir. 1993). The Administrative Law Judge, as trier-of-fact, has the authority, and the duty, to review the record evidence *de novo* and is bound to consider the entirety of the evidentiary record, and not merely the newly submitted evidence, in making a finding in regard to a mistake in a determination of fact in relation to a request for modification. *See Nataloni v. Director, OWCP*, 17 BLR 1-82, 1-84 (1993); *Kovac v. BCNR Mining Corp.*, 14 BLR 1-156 (1990), *modified on recon.*, 16 BLR 1-71 (1992); *see also Jessee*, 5 F.3d at 725, 18 BLR at 2-28; *see generally, O'Keeffe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971). In determining whether a change in conditions has occurred, an Administrative Law Judge must "perform an independent assessment of the newly submitted evidence, in conjunction with evidence previously submitted, to determine if the weight of the new evidence is sufficient to establish the element or elements which defeated entitlement in the prior decision." *See Nataloni v. Director. OWCP*, 17 BLR 1-82, 1-84 (1993); *Kingery v. Hunt Branch Coal Co.*, 19 BLR 1-6 (1994); *Napier v. Director, OWCP*, 17 BLR 1-111 (1993).

In his November 10, 1997 denial of the claim, Judge Levin held that the evidence established the existence of pneumoconiosis which arose out of the Claimant's former coal mine employment, but failed to establish total disability or total disability due to pneumoconiosis. Therefore, the evidence of record before Judge Levin must be reviewed for a mistake in a determination of fact and utilized in conjunction with the newly submitted evidence to determine whether the Claimant has experienced a change in conditions. Even if a mistake in a determination of fact is found or it is determined that a change in conditions occurred, the evidence in its entirety must establish all elements of entitlement for the Claimant to be successful in his request for benefits based on a successful request for modification.

Evidence Submitted in Conjunction with Claimant's Request for Modification

X-ray Evidence[4]

Exhibit No.	X-ray Date	Reading Date	Physician/ Qualifications	Interpretation
E-17	7/1/96	5/24/01	Wheeler B/R	0/1, s/q; minimal ill defined mixed linear and possibly small nodular infiltrates in lateral periphery upper lobes and probably in lower apices compatible with granulomatous disease, TB more likely than histoplasmosis. A few small nodules could be pneumoconiosis but involvement of lateral portion upper lobes favors granulomatous disease while a central symmetrical pattern in mid and upper lungs would favor silicosis or coal workers' pneumoconiosis.
E-17	7/1/96	5/24/01	Scott B/R	0/0; peripheral linear infiltrates and/or fibrosis upper lungs compatible with TB, unknown activity
E-20	7/1/96	6/21/01	Kim B/R	0/0; focal fibrosis or infiltrates in the periphery of both upper lungs. Probably granulomatous process, unknown activity
E-7	11/19/96	2/12/01	Wheeler B/R	0/1, s/q; a few nodules in this case could be pneumoconiosis but peripheral upper lung disease with linear scars and pleural involvement all favor TB or other granulomatous disease since silicosis and CWP give symmetrical small nodules usually in central portion LIND and upper lungs which are largely spared in this case.
E-7	11/19/96	2/12/01	Scott B/R	0/0; predominantly peripheral and linear scarring central portion both upper lungs probably due to TB, unknown activity
D-13	11/19/96	3/8/01	Kim B/R	0/0; nodular infiltrates or fibrosis in the upper lung bilateral prob. granulomatous process unknown activity
D-14	11/19/96	5/16/01	Dahhan B	1/1, q/q; co

[4] The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "R". An interpretation of "0/0"signifies that the film was read completely negative for pneumoconiosis.

E-17	11/19/96	6/2/01	Castle B	1/1, r/t
E-18	11/19/96	6/12/01	Morgan B	0/0; there are some nodules present in the lungs on both sides, and these are most apparent in the mid and lower zones. In the upper zones there are linear opacities at the second and third left interspace and also behind the second right rib. This does not look like coal workers' pneumoconiosis
D-84	4/10/00	4/10/00	Hippensteel B	1/2, r/t; coalescence without development of large opacities
D-85	4/10/00	5/9/00	Wheeler B/R	0/1, s/q; few nodules in this case could be pneumoconiosis but peripheral upper lung disease with linear scars and pleural involvement all favor TB or other granulomatous disease since silicosis and CWP give symmetrical small nodules usually in central portion and upper lungs which are largely spared in this case
D-85	4/10/00	5/9/00	Scott B/R	0/0; linear and nodular fibrosis and/or infiltrates periphery of upper zones compatible with TB, unknown activity
D-91	4/10/00	7/11/00	Kim B/R	0/0; nodular with linear component fibrosis probably granulomatous process of unknown activity
D-92	4/10/00	8/27/00	Shipley B/R	1/1, q/q; coalescence
E-1	4/10/00	9/20/00	Wiot B/R	1/2, q/t; coalescence
E-2	4/10/00	10/29/00	Spitz B/R	1/2, q/r; coalescence
E-14	4/10/00	5/16/01	Dahhan B	1/1, q/q; coalescence; co
E-17	4/10/00	6/2/01	Castle B	1/1, r/t
E-18	4/10/00	6/12/01	Morgan B	0/0; appearances are similar to those in the film of 1996, however the infiltrate shows rather more in the more recent film but I do not believe it has significantly increased in size
C-2	1/5/01	1/7/01	DePonte B/R	1/1, r/q, A
E-11	1/5/01	3/16/01	Wiot B/R	1/2, q/t; coalescence
E-12	1/5/01	3/23/01	Spitz B/R	1/2, q/q; coalescence and linear strands

E-15	1/5/01	5/19/01	Wheeler B/R	0/0; minimal focal and linear interstitial infiltrates or fibrosis mainly in lateral portion LUL > RUL with minimal pleural fibrosis and probable few tiny calcified Granulomata comparable with TB unknown activity, probably healed
E-15	1/5/01	5/18/01	Scott B/R	0/0; predominantly linear scarring peripheral R & L mid-upper lung extending to pleura with calcified granuloma lateral left lung. Changes are probably healed TB although activity cannot be excluded.
E-18	1/5/01	4/10/01	Perme R[5]	2/2, q/t; coalescence
E-20	1/5/01	6/21/01	Kim B/R	0/0; focal linear densities in the periphery of both upper lungs probably calcified granulomata--left upper lobe above findings probably represent granulomatous process of unknown activity

Pulmonary Function Study[6, 7]

Exh. No.	**Date**	**Physician**	**Ht/ age**	**FEV_1**	**FV C**	**MVV**	**Co-op./Undst./ Tracings**	**Qualify**
D-84	4/10/00	Hippensteel	68" 59	2.92 2.85	3.65 3.47	110	--/--/ Yes	No

Arterial Blood Gas Study[8]

[5] This tribunal could not ascertain whether Dr. Perme was a NIOSH certified B-reader at the time of this interpretation. His last certification of record ended on December 31, 2000, and there is no evidence of its renewal.

[6] Second set of entries, if any, on the same test relates to results after administration of bronchodilators.

[7] Pursuant to §718.103 and Appendix B to Part 718, conforming pulmonary function studies require that the miner's level of cooperation and understanding of the procedures be recorded, and that the record of the studies include three tracings. To be qualifying, the FEV1 as well as the MVV or FVC values must equal or fall below the applicable table values found at Part 718, Appendices B and C.

[8] Qualifying arterial blood gas study values are equal to or less than the applicable table values found at Appendix C of Part 718.

Exhibit	Date	Physician	pO_2	pCO_2	Qualifying
D-84	4/10/00	Hippensteel	86.4	38.9	No

Ct Scan Evidence[9]

Exhibit No.	Date of CT	Reading Date	Physician/ Qualifications	Interpretation
D-71, 82; C-1	11/7/96	11/7/96	Legendre R	1. Anterior mediastinal mass consistent with possible adenopathy, thymic tumor, teratoma, or possible substernal thyroid 2. Extensive interstitial changes in a patient with reported history of pneumoconiosis. Small nodular densities may represent focal areas of scarring however a more aggressive process cannot be excluded
D-72	11/7/96	12/19/97	Crawford R	1. There appears to be granulomatous scarring in the lungs with interstitial and parenchymal components. 2. There are multiple small nodules throughout the lungs varying between 4 and 10 mm. in size.
D-83	11/7/96	12/14/99	Wheeler B/R	1. Pneumonia or TB unknown activity with: small infiltrate or fibrosis lateral periphery LUL and posterolateral portion RUL/probable tiny calcified granuloma near left lateral pleura/ 7 mm. nodule in posterolateral periphery RUL compatible with granuloma. 2. Tiny scar in lateral portion right CPA due to healed pneumonia or infract and tiny discoid atelectasis or scar in right posterior CPA. 3. No pneumoconiosis.

[9] Although their credentials are not of record, this tribunal takes judicial notice that the relevant qualifications of Drs. Legendre, Crawford, and Navani are disclosed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990)

D-83	11/7/96	12/27/99	Scott B/R	Peripheral upper lung infiltrates and/or fibrosis probably due to TB, unknown activity. No evidence of silicosis/CWP.
E-16	11/7/96	5/25/01	Kim B/R	Focal patchy densities in posterior lateral aspects of both upper lobes, probably fibrosis due to granulomatous process of unknown activity. No pneumoconiosis.
E-19	11/7/96	6/14/01	Wiot B/R	1. No evidence of coal workers' pneumoconiosis. 2. There are a few peripheral rounded and irregular shadows associated with pleural disease in both upper lobes, sparing the apices. This is much more consistent with old granulomatous disease than coal workers' pneumoconiosis. 3. There is also an areas of air space disease in the left upper lobe, again consistent with granulomatous disease, not coal workers' pneumoconiosis.
E-19	11/7/96	6/14/01	Meyer B/R	Bilateral linear and nodular opacities in the upper lobes which are peripheral and patchy in distribution with associated pleural thickening. This favors a post-inflammatory granulomatous process over coal workers' pneumoconiosis.
E-21	11/7/96	6/22/01	Spitz B/R	No evidence of coal workers' pneumoconiosis. The infiltrate and pleural disease is probably on the bases of previous granulomatous disease.

D-73	1/12/98	1/12/98	Crawford R	1. There appears to be diffuse granulomatous scarring in the lungs with interstitial and parenchymal components. 2. There appears to be some areas of conglomerate scarring in the mid lung fields, particularly on the left side. There also appear to be areas of pleural reaction along the lateral posterior chest walls. 3. There appear to be multiple small nodules throughout the lungs varying between approximately 5 and 10 mm. in size. These were described in a report evaluating an outside CT study on 12/19/97. However, the outside films were not available for comparison at this time.
D-74, C-1	1/12/98	1/22/98	Bassali B/R	1. A large opacity, Size A, is seen in the outer aspect of the let upper lung field. The opacity is very irregular. Rule out carcinoma. 2. Severe diffuse chronic interstitial lung disease seen consistent with complicated coal workers' pneumoconiosis category A, superimposed upon pneumoconiosis type r/u, profusion 3/3, affecting all six lung zones. 3 Bilateral wall pleural plaques are seen in the upper chest, as described. 4. The association of the above findings with history of exposure to coal dust during work is diagnostic of coal workers' pneumoconiosis as above described. 5. There is progression of pneumoconiosis since previous studies of 1986, as well as 1995.
D-75	1/12/98	9/27/99	Navani B/R	Utilized an ILO form: 2/2, q/t, A--left upper zone, coalescence
D-83	1/12/98	12/14/99	Wheeler B/R	1. Infiltrates or fibrosis in lateral portion RUL increasing since last CT scan and involving pleura and infiltrate or fibrosis in lateral portion LUL with 2.5 cm. mass near lateral pleura compatible with pneumonia or TB. Check for clinically active disease. 2. No pneumoconiosis.

D-83	1/12/98	12/27/99	Scott B/R	Peripheral infiltrates and/or fibrosis upper zones with extension to pleura: change probably due to TB or unknown activity. Changes increased slightly since November 1996.
E-6	1/12/98	2/12/01	Kim B/R	Focal infiltrates in both upper lungs with extension to pleura. Probably granulomatous process, unknown activity.

Medical Opinion Evidence

Miscellaneous reports submitted with Director's Exhibit 82 and Claimant's Exhibit 1 indicate that the Claimant had negative PPD skin tests for tuberculosis on January 29, 1997 and March 17, 2000.

The record contains a letter dated April 8, 2000, by Dr. Forehand, board-certified in pediatrics and allergy and immunology and a NIOSH certified B-reader, addressed to the Stone Mountain Health Clinic. (D-82, C-1). In that letter, Dr. Forehand explained that he had been treating the Claimant for three years and that the Claimant was employed as a driller and blaster for seventeen years. Dr. Forehand indicated that the Claimant's chest x-ray has been abnormal for a number of years with coal workers' pneumoconiosis/silicosis. After noting that some individuals with radiographic coal workers' pneumoconiosis are disabled by lung injury, Dr. Forehand stated that the Claimant's arterial oxygen saturation drops with exercise, "pointing to his lung disease and preventing him from working in dusty, strenuous conditions." Dr. Forehand declared that the Claimant's disabling lung disease has arisen from his driller/blaster employment. He explained that the Claimant's x-ray and pattern of impairment and exercise-induced hypoxemia are characteristic for coal workers' pneumoconiosis, and that, because Claimant has never smoked cigarettes and does not have a history of asthma, coal workers' pneumoconiosis is the confirmed principal cause of the Claimant's lung disease. Dr. Forehand concluded his letter by stating that the Claimant is totally and permanently disabled.

In a July 19, 2001 letter to Claimant's attorney, Dr. Forehand indicated that the Claimant's radiographic evidence of coal workers' pneumoconiosis "came about" because hard rock drilling generates extremely high levels of hard rock dust and the Claimant was not provided with means to prevent exposure to hard rock dust generated as a surface mine driller. (C-3). Dr. Forehand stated that due his "lung injury," Claimant would be unable to return to his last job as a hard rock driller without significantly jeopardizing his already impaired respiratory health.

Dr. Hippensteel, board-certified in internal medicine and the subspecialties of pulmonary diseases and critical care medicine, examined the Claimant on April 10, 2000, and reviewed additional extensive specified medical evidence for his May 3, 2000 report. (D-84). Dr. Hippensteel recorded a seventeen year coal mine employment history, and work involving drilling and blasting and road construction from 1964 to 1975 and from 1993 to 1994. Dr. Hippensteel noted significant silica

exposure. Claimant reported that he never smoked, but chews tobacco. Dr. Hippensteel, who is a B-reader, interpreted Claimant's x-ray as consistent with simple coal workers' pneumoconiosis with a classification of r/t, 1/2, with some coalescence in both axillary areas with small nodules which are still well defined, and, therefore, do not qualify as large opacities. Claimant's electrocardiogram showed a sinus bradycardia secondary to medication associated with significant left ventricular hypertrophy with strain or ischemia. These findings along with the Claimant's elevated blood pressure medically contraindicated exercising him. Claimant's spirometry showed normal ventilatory function based upon normal values for either Black or Caucasian races. Claimant's lung volumes, diffusion capacity, and MVV were all also normal.

Based on his examination of the Claimant, Dr. Hippensteel diagnosed simple coal workers' pneumoconiosis. He concluded that from a functional standpoint, the objective evidence indicates that the Claimant retains normal ventilatory and gas exchange function. Dr. Hippensteel opined that the Claimant's normal objective tests in conjunction with the radiological evidence that there remain well-defined nodules in areas of coalescence contradict a finding of complicated coal workers' pneumoconiosis. Dr. Hippensteel concluded that the Claimant has severe hypertension and severe cardiac effects from this hypertension, which was not well controlled at the time of the examination. Dr. Hippensteel opined that the Claimant's heart condition is not related to his prior coal dust exposure nor is it secondary to lung disease, since the Claimant's lung function is normal on testing. Dr. Hippensteel opined the Claimant is totally disabled by his hypertensive cardiovascular disease, and could not return to his previous job in the mines or any similar occupation. Review of additional medical evidence, caused Dr. Hippensteel to affirm his findings based on examination of the Claimant. Dr. Hippensteel was deposed on March 7, 2001 (E-10).

Dr. Repsher, board-certified in internal medicine and the subspecialties of pulmonary diseases and critical care medicine and a NIOSH certified B-reader, reviewed for his January 29, 2001 report specified medical evidence developed subsequent to his previous report of April 29, 1997. (E-3). Dr. Repsher opined that Dr. Forehand's April 8, 2000 letter is not a reasoned opinion. In support of his conclusion, Dr. Repsher noted that Dr. Forehand ignores the fact that exertional hypoxemia is not only normal in some individuals, but can be caused by a host of other conditions other than smoking or asthma. Dr. Repsher further explained that a very common cause of exertional hypoxemia is especially relevant in the Claimant's case: ischemic and hypertensive cardiomyopathies. Dr. Repsher was critical of Dr. Forehand's failure to acknowledge the Claimant's long history of severe and increasingly more severe heart problems. Dr. Repsher concluded that there remains equivocal objective evidence to justify a diagnosis of coal workers' pneumoconiosis due to the wide disparity of opinions among the experts. He also concluded that Claimant has no respiratory or pulmonary impairment by objective testing, although he opined that Claimant is probably totally and permanently disabled due solely to his hypertensive and ischemic cardiomyopathies with probable congestive heart failure, unrelated to underlying possible coal workers' pneumoconiosis. Dr. Repsher opined that even if the Claimant were to have documented histologic evidence of coal workers' pneumoconiosis, in view of the Claimant's unequivocally normal pulmonary function tests, his opinion would not change.

Dr. Iosif, board-certified in internal medicine and the subspecialty of pulmonary disease, reviewed specified evidence for his February 6, 2001 report. (E-5). Dr. Iosif opined that, while the presence of simple coal workers' pneumoconiosis has been firmly established by the radiographic evidence, given the Claimant's occupation, it is very likely that Claimant has silicosis with a possible additional component of coal workers' pneumoconiosis. Although he discussed in detail the Claimant's CT scan findings, Dr. Iosif concluded that he was unable to provide a definite answer or opinion in regard to the issue of whether the large fibrotic lesion located in the Claimant's left upper lobe is a fibrotic conglomerate related to silicosis/coal workers' pneumoconiosis in part because he did not have the opportunity to examine the chest CT films himself. Dr. Iosif opined that there was no convincing evidence supporting the existence of any type or degree of primary or intrinsic respiratory functional impairment. In regard to the single instance of a measured drop in exercise pO_2 documented by Dr. Forehand, Dr. Iosif noted that this drop was either a technical error or the result of low cardiac output form underlying cardiomyopathy. Dr. Iosif opined that the Claimant is totally and permanently disabled by his severe cardiomyopathy of a ischemic and/or hypertensive nature unrelated to his previous coal mine employment.

Dr. Castle, board-certified in internal medicine and the subspecialty of pulmonary diseases and a NIOSH certified B-reader, reviewed specified evidence for his February 8, 2001 report. (E-4). Dr. Castle opined that the Claimant has radiographic evidence of simple coal workers' pneumoconiosis, but not evidence of complicated pneumoconiosis. Dr. Castle noted that Claimant continues to show evidence of no respiratory impairment from any cause, a finding contrary to the development of progressive massive fibrosis or complicated coal workers' pneumoconiosis. Dr. Castle opined that the CT scans have not conclusively shown evidence of complicated pneumoconiosis. Dr. Castle concluded that while the Claimant has simple coal workers' pneumoconiosis, he is not permanently and totally disabled by that process or any other process related to his coal mine employment. However, Dr. Castle opined that the Claimant is totally disabled by as a result of both hypertensive cardiovascular disease and ischemic cardiovascular disease, diseases of the general public unrelated to coal dust exposure.

Dr. Dahhan, board-certified in internal medicine and the subspecialty of pulmonary diseases and NIOSH certified B-reader, reviewed extensive specified evidence for his February 9, 2001 report. (E-8). Dr. Dahhan opined that the Claimant has simple, but not complicated, coal workers' pneumoconiosis. He explained that the majority of Claimant's x-rays were not read as complicated coal workers' pneumoconiosis, the majority of the CT scan interpretations did not show any abnormalities indicative of complicated coal workers' pneumoconiosis, he had no clinical evidence of complicated coal workers' pneumoconiosis on examination, and his pulmonary function and arterial blood gas studies showed no evidence consistent with complicated coal workers' pneumoconiosis. Dr. Dahhan concluded that the Claimant has no objective findings consistent with any abnormality in his respiratory mechanics. Dr. Dahhan opined that Claimant's intermittent alterations in his blood gas exchange mechanisms in the face of normal respiratory mechanics indicates that such abnormalities are not due to an intrinsic lung disease. From a strictly respiratory standpoint, Dr. Dahhan opined that the Claimant retains the physiological respiratory capacity to return to his previous coal mine employment or a job of comparable physical demand. Dr. Dahhan

concluded that Claimant's hypertension, hypertensive cardiovascular disease and coronary artery diseases are all conditions of the general public and are unrelated to the inhalation of coal dust or coal workers' pneumoconiosis.

Dr. Spagnolo, board-certified in internal medicine and the subspecialty of pulmonary diseases, reviewed specified evidence for his February 18, 2001 report. (E-9). Dr. Spagnolo opined that the evidence overwhelming establishes that the Claimant does not have a chronic restrictive or obstructive impairment arising out of coal mine employment. He opined that the only physiologic explanation for the Claimant's decreased exercise PaO_2 [pO_2] value obtained by Dr. Forehand is an inadequate cardiac output during the exercise testing. Dr. Spagnolo stated that he therefore agreed with Dr. Iosif and Dr. Repsher, and concluded that the Claimant's documented hypertensive and ischemic heart disease fully accounts for the decrease in PaO_2 [pO_2]. Dr. Spagnolo opined that there was insufficient evidence to justify a diagnosis of coal workers' pneumoconiosis or silicosis based on his attribution of great weigh to the opinions of Drs. Kim, Wheeler, and Scott due to their credentials as university based radiologists. Dr. Spagnolo concluded that from a respiratory standpoint, the Claimant is not totally and permanently disabled and would be able to return to his regular coal mining work as a driller. Dr. Spagnolo concluded that his opinion in regard to the Claimant's respiratory impairment or disability would not change if the Claimant were found to have pneumoconiosis because he has no respiratory impairment.

Judge Levin's Findings in the Claimant's Initial Claim--Reviewed Here for a Mistake in a Determination of Fact Based on the Evidence Before Him and Considered Hereafter to Determine Whether Claimant has Experienced a Change in Conditions

Having reviewed the evidence contained in the evidentiary record before Judge Levin in conjunction with his Decision and Order of November 10, 1997, this tribunal finds that Judge Levin's decision provides a reliable and complete inventory of the evidence submitted with the previous claim except for his failure to indicate that Dr. Forehand read the Claimant's July 1, 1996 film as positive for complicated pneumoconiosis by indicating that there were Category A large opacities and his misdating of the August 17, 1993 pulmonary function study[10] (D-22, 60 at 3-5). Judge Levin's failure to identify and discuss the single positive x-ray interpretation which was positive for complicated pneumoconiosis under §718.304 (a) amounts to a mistake in the process of determining a fact, whether the Claimant's pneumoconiosis is properly classified as complicated pneumoconiosis. However, because this tribunal must reconsider all the evidence of record in conjunction with its consideration of Claimant's request for modification, which is effectively a redetermination of the merits of the claim, and because that x-ray interpretation is significantly outweighed by contrary probative evidence that was before Judge Levin, his misinterpretation of the x-ray has had no effect

[10] Judge Levin identified Employer's Exhibit 4 before him as a pulmonary function study dated May 22, 1997, and performed at the St. Francis Hospital when the Claimant was fifty-seven years old. However, that pulmonary function study, now found in Director's Exhibit 55, was performed on August 17, 1993, when the Claimant was fifty-two years old. Nevertheless, the study did not yield qualifying results.

on the ultimate outcome of the case. Judge Levin found that the radiographic evidence established that the Claimant has pneumoconiosis. In support of his finding, Judge Levin found that the four films of record were unanimously interpreted as positive for pneumoconiosis by nine different physicians with special radiographic qualifications. Because the preponderance of the radiographic evidence overwhelmingly indicates the presence of pneumoconiosis, no mistake in a determination of fact was made by Judge Levin in this regard.

Dr. Forehand, a board-certified B-reader, interpreted the Claimant's July 1, 1996, as positive for pneumoconiosis, type q/q with a profusion of 1/1, and checked the box indicating that there was at least one large Category A opacity. Dr. Forehand also noted coalescence, but did not elaborate on any of his findings, nor did he identify any actual large opacities. (D-22). The July 1, 1996 x-ray was also interpreted by another B-reader and three dually qualified board-certified radiologists and B-readers, none of whom interpreted the film as positive for complicated pneumoconiosis by either indicating the presence of Category A, B, or C large opacities or otherwise identifying massive lesions of pneumoconiosis (D-20, 21, 43). Accordingly, because the film was interpreted as negative for complicated pneumoconiosis by three board-certified radiologists who are also B-readers, the contrary probative evidence establishes that the Claimant did not have complicated pneumoconiosis. Moreover, an x-ray taken four months later on November 19, 1996, was unanimously interpreted by three dually qualified board-certified radiologists and B-readers and one B-reader as positive for simple pneumoconiosis without any evidence of complicated pneumoconiosis (D- 39, 43). Accordingly, the preponderance of the x-ray evidence overwhelmingly establishes that the Claimant did not have complicated pneumoconiosis. Upon review of Judge Levin's decision, the Benefits Review Board did not address his apparent failure to consider Dr. Forehand's x-ray interpretation, and this tribunal finds that the omission was a mistake in a determination of fact of no consequence in light of the its concurrent review of the entire evidentiary record for redetermination of the merits of this claim.

Judge Levin found that Claimant established that his pneumoconiosis arose out of his coal mine employment based on application of the rebuttable presumption at §718.203(b) in light of Claimant's eleven and three-quarters years of coal mine employment and Employer's failure to rebut that presumption. (D-60 at 7). Because Judge Levin correctly found that the Claimant completed over ten years of coal mine employment, and, because Employer did not submit to the record any rebuttal evidence, there was no mistake in a determination of fact in this regard.

Finally, Judge Levin found that Claimant failed to establish that he is totally disabled by a respiratory or pulmonary condition, but found that Claimant is totally disabled by his heart condition unrelated to his pneumoconiosis. The record before Judge Levin did not contain any qualifying pulmonary function studies, nor did it contain any evidence that the Claimant has cor pulmonale with right sided congestive heart failure. The record contained one qualifying exercise arterial blood gas study administered by Dr. Forehand on July 1, 1996, which Judge Levin found to be sufficient evidence to find total disability due to pulmonary disease if it were fully credited over any contrary probative evidence (D-60 at 8, D-15).

With regard to the reasoned medical opinions of record, Judge Levin noted that of eight opining physicians, only one, Dr. Forehand, concluded that the Claimant was totally and permanently disabled due to a pulmonary disease. Again, Judge Levin found that, if Dr. Forehand's opinion were credited over any contrary probative evidence, it would be sufficient evidence to find total disability due to pulmonary disease (D-60 at 9). However, upon consideration of the contrary probative evidence, Judge Levin found that the greater weight of the evidence established that the Claimant is not totally disabled due to a respiratory or pulmonary impairment.

Judge Levin correctly noted that the entirety of the pulmonary function study evidence, even when Claimant exhibited poor effort, produced values indicative of no respiratory impairment. Additionally, he noted that Claimant's more recent arterial blood gas study, administered on March 6, 1997, produced normal values, and that the majority of the physicians who either examined the Claimant or reviewed the evidence of record agreed that there is no evidence of any respiratory impairment or disability. Judge Levin therefore gave less weight to the qualifying exercise portion of the July 1, 1996 arterial blood gas study because its results were not reproducible, because there were multiple nonqualifying pulmonary function studies, and because Dr. Castle questioned the validity of the arterial blood gas study itself. Judge Levin also accorded less weight to Dr. Forehand's opinion because it was based entirely on that qualifying exercise arterial blood gas study.

Judge Levin accorded more weight to the opinion of Dr. Castle because he is highly qualified, because he both examined the Claimant and reviewed the medical record, and because he provided a documented and well-reasoned opinion consistent with the weight of the objective medical evidence of record. Dr. Castle's opinion was also accorded great weight because it was supported by the examination report of Dr. Rasmussen, and the evaluations by Drs. Repsher, Iosif, Fino, and Morgan, who are all highly qualified. Accordingly, while he found some evidence of total respiratory disability, Judge Levin found that it was outweighed by the contrary evidence which established that the Claimant is not totally disabled by a respiratory or pulmonary impairment, but is disabled by his heart condition. (D-60 at 9-10). Thus, there is no mistake in a determination of fact in Judge Levin's findings. The evidence before him overwhelmingly established that the Claimant did not have any respiratory or pulmonary impairment.

The Claim of Total Disability Due to Coal Workers' Pneumoconiosis--a Change in Conditions

Complicated Pneumoconiosis--Applicability of the Presumption Set Forth at §718.304

Section 718.304 provides an irrebuttable presumption that the miner is totally disabled by or that the miner's death was due to pneumoconiosis if the miner is suffering or suffered from a chronic dust disease of the lungs of an advanced degree frequently referred to as complicated pneumoconiosis. *See Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7, 11 (1996); *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 255 (4th Cir. 2000). Section 718.304 sets out three manners in which a claimant may establish the existence of complicated pneumoconiosis: a) diagnosis by x-ray yielding one or more large opacities classified in Category A, B, or C in the International Classification of Radiographs of the Pneumoconioses by the International

Labor Organization; b) diagnosis by biopsy or autopsy yielding massive lesions in the lungs, or c) when diagnosis by means other than those specified by (a) and (b) would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) had diagnosis been made as therein described. Any diagnosis made under paragraph (c) must accord with acceptable medical procedures. §718.304(c). The Benefits Review Board has held that §718.304(a)-(c) do not provide alternative means of establishing the irrebuttable presumption of total disability due to pneumoconiosis, but rather require the administrative law judge to first evaluate the evidence in each category, and then to weigh together the categories at §718.304(a)-(c) prior to invocation. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*); *see also Dennis E. Keene v. G & A Coal Co.*, BRB No. 96-1689 BLA-A (September 27, 1996) (*unpublished*).

In recent decisions, the Fourth Circuit has construed this section and provided additional guidance for analysis consistent with the terms and intent of the section. In the most recent decision on point, the Court in *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250 (4th Cir. 2000), affirmed its position in *Double B Mining Inc. v. Blankenship*, 177 F.3d 240 (4th Cir. 1999) and adopted the Third Circuit's holding in *Clites v. Jones & Laughlin Steel Corp.*, 663 F.2d 14 (3d Cir. 1981), that the three prongs of §718.304 are intended to describe a single, objective condition. *Id.* at 255. Accordingly, as each prong requires a separate analysis, the Court held, "one must perform equivalency determinations to make certain that regardless of which diagnostic technique is used, the same underlying condition triggers the irrebuttable presumption." *Scarbro at 255-256; Blankenship* at 243; *see also Jones Laughlin Steel Corp.* at 16.

In *Blankenship*, the Fourth Circuit elaborated the required equivalency determination, stating:

> Because prong (A) sets up an entirely objective scientific standard, it provides the mechanism for determining equivalencies under prong (B) or prong (C). In prong (A), Congress mandated that the condition that triggers the irrebuttable presumption is one that creates, on an x-ray, at least one opacity greater than one centimeter in diameter. When that condition is diagnosed by biopsy rather than x-ray, it must therefore be determined whether the biopsy results show a condition that would produce opacities of greater than one centimeter in diameter on an x-ray. That is to say, "massive lesions," as described in prong (B), are lesions that when x-rayed, show as opacities greater than one centimeter in diameter.

Blankenship at 243. The Court recognized that it might be necessary for an ALJ to make a separate equivalency determination each time a miner presents evidence of massive lesions diagnosed by biopsy. *Id.* at 244. The Court stated that "the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they appear to be perhaps because of an intervening pathology, some technical problem with the equipment used, or incompetence of

the reader." *Scarbro* at 256.

X-ray Evidence under Prong (a) of §718.304

The record contains evidence of six chest x-rays reviewed by seventeen physicians for a total of forty-one x-ray interpretations. Of these seventeen physicians, seven are B-readers, nine are dually qualified board-certified radiologists and B-readers, and one is a board-certified radiologist. Prong (a) of §718.304 dictates that the presumption is established by x-rays yielding one or more large opacities greater than 1.0 centimeter in diameter that would be classified in Category A, B or C in the ILO-U/C International Classification of Radiographs of the Pneumoconioses. Of the seventeen physicians, only Dr. Forehand, a B-reader, and Dr. DePonte, a board-certified radiologist and B-reader, each interpreted a single film as positive for complicated pneumoconiosis, Category A (D-22, C-2).

As discussed earlier, Dr. Forehand interpreted the July 1, 1996 x-ray as positive for complicated pneumoconiosis, Category A, without explicitly identifying any large opacities (D-22). The record before Judge Levin contained ample evidence brought forth by dually qualified board-certified radiologists and additional B-readers which refuted Dr. Forehand's finding. Additionally, that same film was reinterpreted by three additional dually qualified board-certified radiologists and B-readers in the instant request for modification, and all three interpreted the film as not only negative for complicated pneumoconiosis, but negative for pneumoconiosis in general (E-17, 20). Those physicians, Drs. Kim, Wheeler and Scott, opined that the Claimant lung markings were more likely caused by a granulomatous process. Nevertheless, there remains sufficient evidence based on re-readings of the July 1, 1996 film to refute Dr. Forehand's opinion.

Additionally, of the three films taken subsequent to the July 1, 1996 film, and interpreted twenty-seven times, only one interpretation is positive for complicated pneumoconiosis. Dr. DePonte interpreted the January 5, 2001 film as positive for complicated pneumoconiosis, Category A, without explicitly identifying any large opacities (C-22). Drs. Wiot and Spitz, both of whom are dually qualified board-certified radiologists and B-readers, and Dr. Perme, a board-certified radiologist, interpreted the film as positive for simple pneumoconiosis only, and noted that there is coalescence (E-11, 1218). Drs. Wheeler, Scott, and Kim, all opined again that the Claimant lung markings were more likely caused by a granulomatous process. The two films taken in between the July 1, 1996 film and the January 5, 2001 film, dated November 19, 1996 and April 10, 2000, were unanimously interpreted as negative for complicated pneumoconiosis by six dually qualified board-certified radiologists and B-readers, and four B-readers. Several of those physicians noted the presence of coalescence (D-84, 92; E-1, 2, 14). Dr. Hippensteel, a B-reader who interpreted the April 10, 2000 film, explained that, while areas of coalescence are visible in the Claimant's x-ray because individual opacities remain visible, such coalesced areas are not large opacities under the ILO system (D-84). Because the preponderance of the radiographic evidence, including that of the most recent chest-x-ray, indicates that the Claimant has simple pneumoconiosis only, with possible coalescence, which several well-qualified physicians indicated does not equal a finding of complicated pneumoconiosis under the ILO system, this tribunal finds that the Claimant has not established the existence of complicated pneumoconiosis by the preponderance of x-ray evidence under prong (a).

Biopsy and/or Autopsy Evidence under Prong (b)

The record contains no biopsy or autopsy evidence for consideration under prong (b).

Diagnosis by Other Equivalent Means under Prong (c)

Under prong (c), the irrebuttable presumption may be invoked where the miner suffered from a chronic lung disease which when diagnosed by means other than those described in prongs (a) and (b) would be a condition which could reasonably be expected to yield the massive lesions described in prongs (a) and (b). The language indicates that the diagnosis need not actually identify the existence of massive lesions. Instead, it is the disease process behind the formation of massive lesions which must be diagnosed, that disease process being complicated pneumoconiosis. S*ee Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7, 11 (1996); *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 255 (4th Cir. 2000). In this case, there are two forms of evidence under prong (c): CT scan interpretations and medical opinions. *See Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*).

Ten physicians interpreted the two CT scans in this case a total of fourteen times. The November 7, 1996 CT scan was reviewed by eight board-certified radiologists. None of those radiologists identified nodules or opacities of pneumoconiosis or a disease process behind the formation of such lesions. While Dr. Crawford noted the presence of multiple small nodules throughout the Claimant's lungs varying between 4 and 10 mm. in size, Dr. Crawford described these nodules as evidence of interstitial and parenchymal scarring, which he did not relate to any particular disease process. (D-72). Accordingly, because he neither identified massive lesions nor diagnosed pneumoconiosis, Dr. Crawford's opinion does not support a finding of complicated pneumoconiosis.

Six board-certified radiologists reviewed the January 12, 1998 CT scan. Again, Dr. Crawford's interpretation does not rise to the level of a diagnosis of complicated pneumoconiosis because he failed to relate the finding of nodules to up to 10 mm. in size to any disease process (D-73). However, two board-certified radiologists, Drs. Bassali and Navani, made specific findings that the Claimant has complicated pneumoconiosis based on their interpretation of the January 12, 1998 CT scan. Dr. Bassali's conclusion that the CT scan evidenced severe diffuse chronic interstitial lung disease consistent with complicated pneumoconiosis Category A is sufficient evidence, if credited over all contrary evidence under this prong, to establish the existence of complicated pneumoconiosis (D-74). Dr. Navani utilized an ILO form to interpret the CT scan as positive for complicated pneumoconiosis, which he did by indicating the presence of a Category A large mass in the "left upper zone" (D-75). Dr. Navani's use of an ILO form to interpret the CT is improper in that the ILO forms are designed for the classification of radiographs only. Dr. Navani neither described the size of the opacity, nor did he associate it with Claimant's pneumoconiosis, though one could infer that his use of the ILO form indicated such intent. Nevertheless, because his interpretation does not indicate whether the noted opacity would yield the massive lesions described in prongs (a) and (b), and because it does not identify the disease process behind the formation of that opacity, Dr. Navani's opinion is insufficient to establish the existence of complicated pneumoconiosis. The three remaining radiologists all opined that the CT scan revealed evidence of infiltrates and fibrosis associated with

disease processes other than pneumoconiosis (D-83; E-6).

Drs. Hippensteel, Castle, and Dahhan, all board-certified in internal medicine and the subspecialty of pulmonary diseases, provided reasoned medical opinions based on reviews of extensive medical evidence that the Claimant does not have complicated pneumoconiosis. All three physicians based their conclusions on the lack of conclusive CT scan and radiographic evidence of complicated pneumoconiosis and Claimant's lack of any respiratory or pulmonary impairment, a finding they characterized as contrary to the development of the disease process behind complicated pneumoconiosis (D-84; E-4, 8, 10 at 21). Dr. Iosif, also board-certified in internal medicine and the subspecialty of pulmonary diseases, was unable to conclude from the CT scan interpretations whether the Claimant has complicated pneumoconiosis or a fibrotic conglomerate, and indicated that he was hindered by his inability to review the CT scans himself (E-5). Drs. Repsher and Spagnolo, both board-certified in internal medicine and the subspecialty of pulmonary diseases, also reviewed extensive medical evidence, and opined that the largely equivocal objective evidence was insufficient to support a diagnosis of pneumoconiosis in any form (E-3, 9).

The preponderance of the evidence under this prong indicates that the Claimant does not have complicated pneumoconiosis. Although Dr. Bassali's opinion imputes a diagnosis of complicated pneumoconiosis to the January 12, 1998 CT scan, his opinion is equivocal in light of his other findings in regard to that CT scan. While Dr. Bassali ultimately concluded in his "Impression" that the Claimant has a disease "consistent with complicated pneumoconiosis category A," his findings indicate that he diagnosed severe diffuse chronic interstitial lung disease consistent with severe simple pneumoconiosis in conjunction with a large, very irregular size A opacity in the left upper lung field for which he advised a complete work up for carcinoma including cytology and bronchoscopy. The record does not indicate that any such work up was completed. However, Dr. Bassali apparently felt justified in concluding that the size A opacity was evidence of complicated pneumoconiosis without the suggested follow up. Because he provided no rationale, this tribunal cannot find a correlation between the equivocal disease process identified by Dr. Bassali and the existence of at least one opacity which would yield the massive lesions described in prongs (a) and (b). Therefore, Dr. Bassali's failure to reconcile his findings in regard to the January 12, 1998 CT scan effectively lessens the probative force of his opinion.

Additionally, twelve CT scan interpretations, and six reasoned medical opinions indicate that Claimant does not have a disease process which would produce the characteristic massive lesions of complicated pneumoconiosis. The only evidence under this prong supportive of Dr. Bassali's opinion is the CT scan interpretation of Dr. Navani. However, Dr. Navani's opinion that Claimant has complicated pneumoconiosis is based solely on the identification of the left upper lung opacity, which has not been unequivocally associated with pneumoconiosis, and has been speculatively related on the remand before this tribunal to carcinoma, a granulomatous process, an air space disease, pneumonia, tuberculosis, and/or coalescence of nodules of simple coal workers' pneumoconiosis (D-71, 82, 83, 84; C-1; E-10, 19). Accordingly, the evidence in this case under prong (c) is, at best, inconclusive, and does not support a finding of complicated pneumoconiosis under §718.304 or that Claimant has experienced a change in conditions.

Total Disability

To establish total disability, Claimant must establish by a preponderance of the evidence that the Miner had a pulmonary or respiratory impairment, which, standing alone, prevented the miner from performing his usual coal mine work or work requiring comparable skills. §718.204((b)(1). Section 718.204(b)(2) provides the criteria for determining whether a miner is totally disabled by a respiratory or pulmonary impairment. These criteria are: (1) pulmonary function tests qualifying under applicable regulatory standards; (2) arterial blood gas studies qualifying under applicable regulatory standards; (3) proof of pneumoconiosis and cor pulmonale with right sided congestive heart failure; or (4) proof of a disabling respiratory or pulmonary condition on the basis of the reasoned medical opinion of a physician relying upon medically acceptable clinical and laboratory diagnostic techniques.

The four pulmonary function tests conducted between February 1986 and December 1996, which were before Judge Levin, did not produce qualifying values, and the test performed most recently, on April 10, 2000, also did not yield qualifying values (D-9,13, 39, 55, 84). There is no evidence that the Claimant suffers from cor pulmonale with right sided congestive heart failure. Therefore, the Claimant cannot establish total disability under §718.204(b)(2)(i) or (iii).

The record contains three arterial blood gas studies conducted between July 1996 and April 2000. All three resting studies produced non-qualifying results (D-15, 51, 84). Due to the Claimant's documented hypertension, exercise testing was contraindicated in the two most recent studies of March 6, 1997 and April 10, 2000 (D-51, 84). However, Claimant performed an exercise study on July 1, 1996 in conjunction with his examination by Dr. Forehand (D-15). That study yielded qualifying results. However, the validity of that test was questioned upon review in a well-reasoned opinion by Dr. Castle, and the results of the test could not be repeated (D-39). Dr. Iosif also reviewed the study and questioned its validity based on a technical error (E-5). Accordingly, less weight is accorded to the results of the exercise arterial blood gas test because its validity has been questioned by qualified pulmonary specialists, its results were not duplicated, and there are multiple non-qualifying resting studies, one of which was performed almost four years later. Therefore, the Claimant has not established total disability under §718.204(b)(2)(ii).

The reasoned medical opinions of record also do not establish that the Claimant is totally disabled by a respiratory or pulmonary impairment under §718.204(b)(iv). Dr. Forehand remains the only physician of record to opine that the Claimant is totally disabled by a respiratory or pulmonary impairment. Judge Levin accorded his opinion little weight because it was based entirely on the Claimant's qualifying exercise arterial blood gas study, which is not itself probative of the Claimant's respiratory condition (D-14, 60 at 9). Dr. Forehand provided little by way of clarification of his opinion in Claimant's current request for modification. Without providing any rationale, Dr. Forehand conclusively stated in a letter that the Claimant's arterial oxygenation drop with exercise points to his lung disease, which is disabling (D-82, C-1). Although Dr. Forehand holds himself out as Claimant's treating physician for the past three years, and Claimant considers Dr. Forehand to be his treating physician based on bi-yearly visits, Dr. Forehand exhibits no apparent knowledge of the Claimant's significant heart problems. Nor is it apparent that Dr. Forehand has tested the Claimant's

pulmonary function since 1996. (D-82, C-1; Tr. 21). Moreover, Dr. Forehand either did not review or has completely ignored without explanation the Claimant's recent and historically normal pulmonary function and resting arterial blood gas testing, which mitigate against a finding of total respiratory or pulmonary disability. Finally, Dr. Forehand is not a pulmonary specialist, and, as a pediatric and allergy and immunology specialist, displays no particular qualifications to treat the Claimant for any respiratory or pulmonary impairments he may have. Accordingly, although he might qualify as the Claimant's treating physician pursuant to and in consideration of §718.104(d), Dr. Forehand's opinion is entitled to little weight.

Drs. Hippensteel, Repsher, Iosif, Castle, Dahhan, Spagnolo, Fino and Morgan, all of whom are board-certified in internal and pulmonary medicine, opined in well-reasoned opinions based on extensive review of pertinent medical evidence that the Claimant has no respiratory or pulmonary impairment whatsoever (D-39, 53, 56, 57, 58, 84; E-3, 4, 5, 8, 9, 10). Instead, of those physicians who opined as to whether the Claimant is totally disabled all agreed that he is totally disabled by his hypertensive cardiovascular disease and ischemic cardiovascular disease, both diseases of the general public and unrelated to coal mine dust exposure (D-53, 56, 84; E-3, 4, 8,10). The corroborative opinions of these opining physicians are consistent with the objective evidence, well-documented, and indicate an in depth understanding of the Claimant's condition. They are, therefore, entitled to controlling weight. Thus, the overwhelming preponderance of the evidence establishes that the Claimant is not totally disabled due to a respiratory or pulmonary impairment, and therefore, that he has not experienced a change in conditions since the denial of his prior claim.

ORDER

Claimant Robert Bell's request for modification of his claim for Black Lung benefits is denied.

A
EDWARD TERHUNE MILLER
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any interested party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. A copy of the notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.